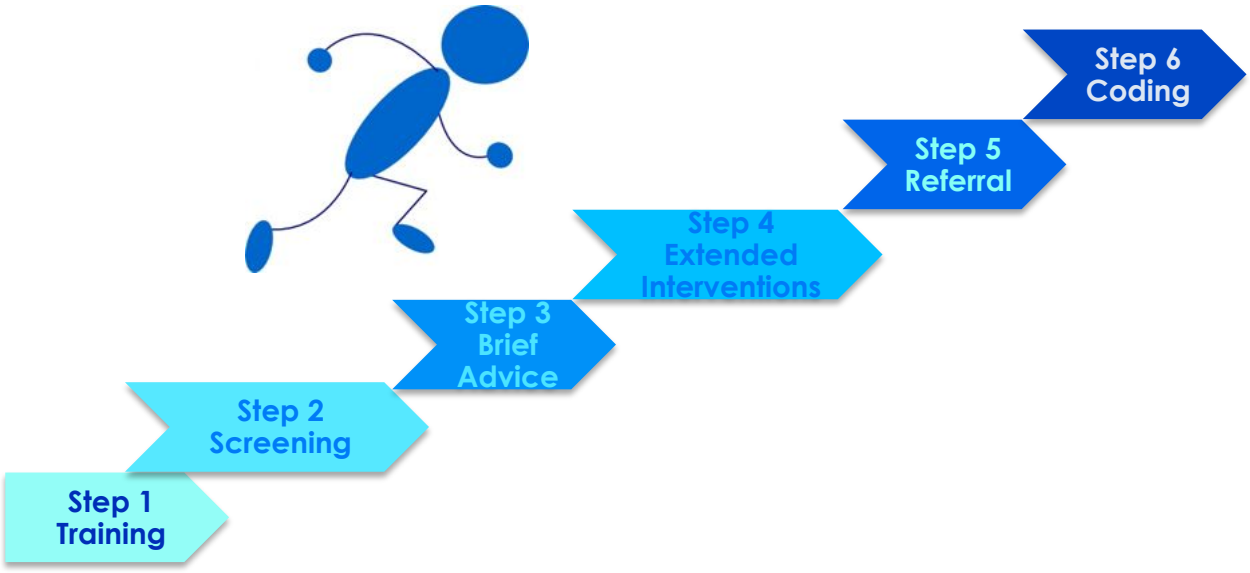
Improving the Delivery of the Alcohol Direct Enhanced Service:

A Step-By-Step Guide for Commissioners, Primary Care Practitioners and Practice Managers



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with you in recovery

Acknowledgements

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With special thanks to the four practices in Haringey that participated in our review.

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Why use this guide?

How many patients in your practice or local area do you think are regularly drinking at risky levels?

In England, **1 in 4** people aged over 16 years old regularly drink above the recommended limits. That means that **25%** of your practice or regional population would benefit from being screened and offered some form of intervention, be it brief or long-term.

Do your practice-level or borough-level annual alcohol DES returns reflect these statistics?

This guide began with **Haringey Drug and Alcohol Action Team (DAAT)** asking just this question and finding that the answer was no. During 2009-2010, twenty-nine Haringey practices provided the alcohol DES. The percentage of new registrations screened varied considerably from **24% to 100%**. Of those new registrations screened locally, **only 2% screened positive (347 patients)**. Over half of participating practices **failed to identify any patients as AUDIT positive,** whilst others identified **100% of their patients as AUDIT positive**. **It is of serious concern that in a year only ten patients were referred for specialist alcohol treatment as a result of alcohol DES screening across the borough**.

Haringey DAAT decided to review local alcohol DES delivery to inform best practice guidance on how to deliver the alcohol DES. The review (**outlined on pages 29-31**) found, to give just two examples, that **75% of practices were using incorrect screening questions,** and **that only 50% of practices were offering face-to-face Brief Advice.** Crucially for practices, we also found that practices were **losing money due to DES returns that did not reflect the work that they had done**.

It is important to recognise that the alcohol DES is ***not a data collection exercise*** but rather an attempt to **identify and support people to make positive changes to their drinking**. Alcohol screening and intervention at point of entry to primary care is an exercise in **prevention**, **early identification** and **early intervention**. **Alcohol misuse costs the NHS alone over £2.7 million**.

Identification and Brief Advice (IBA)—also known as Screening and Brief Interventions (SBI)—boasts **a persuasive and ever-growing evidence base (see page 25).** This is recognised by its prominence in the latest alcohol-related National Institute of Clinical Excellence (NICE) guidance (NICE 2010; 2011).

Following **our Step-by-Step Guide**—which is based on our review findings and HAGA's years of experience in delivering IBA projects—**will help practices to maximise their income, whilst also offering better healthcare for patients**. This guide updates and collates various guidance documents on the alcohol DES and IBA in primary care, so that you can get all the information you need in one place.

This guidance has been written by HAGA, commissioned by Haringey DAAT and is supported by the Department of Health. The review on which we have based this guidance has been cited as an **example of best practice** in *Intensive Support in Reducing Hospital Admissions* (Currie 2010).

How to use this guide

This guide is designed to be as practical and user-friendly as possible.

Readers will find some sections more useful for their purposes than others.

Practice Managers should focus on the **Step-By-Step Guide,** found in **Section I**. This will take you through the key areas for consideration in reviewing and improving your alcohol DES processes, or, where you are not yet participating, in implementing the alcohol DES in your practice.

Nurses and **Healthcare Assistants** might also be interested to assess their own practice and the pathway within surgery against the **Step-By-Step Guide,** found in **Section I**.

GPs will find something of interest in every section of this document as the **DES Review** and **Review Findings,** found in **Sections III and IV,** will give you an idea of the widespread errors found at practice level and the **Step-By-Step Guide** found in **Section I** will explain how to ensure your practice is compliant with best practice.

Commissioners will find the **DES Review** and **Review Findings,** found in **Sections III and IV,** useful in planning their own review of local alcohol DES processes.

All readers will find the **Alcohol DES Checklist** on **Page 7**, the **pathway examples** on **Pages 5 and 6,** and the **AUDIT** and **Brief Advice tools** in **Appendix B and C,** of use.

All the tools supporting this guidance can be found in the **Appendix** and can be **downloaded from HAGA's website** at www.haga.co.uk/Tools under "**Alcohol DES Guidance Tools for Primary Care**."

I. Step-By-Step Guide

This section will be useful for both **Practice Managers** and those **practitioners delivering the alcohol DES within the practice**, as well as those **GPs**, **Nurses** and **Healthcare Assistants** who wish to ensure that your practice is in line with best practice.

Each section of our **Step-By-Step Guide** includes a **mini-checklist** and an explanation of how to improve in the given area. When, you have read through each section, you can use the **full checklist** on **page 7** to **audit your alcohol DES processes**.

ALCOHOL DES CHECKLIST

STEP 1 TRAINING

- ☐ On-going Identification & Brief Advice (IBA) training programme for clinical & administrative staff
- ☐ All staff conducting IBA to complete e-learning module as a minimum

STEP 2 SCREENING

- ☐ Decide when & how to screen
- ☐ Review & revise your registration form
  - ☐ Check carefully whether you are using the correct AUDIT-C, FAST & AUDIT questions
  - ☐ Ensure that the relationship between initial screens (AUDIT-C & FAST) & AUDIT (full screen) is understood within your practice
  - ☐ Add a clear unit guide (where patients self-complete)
  - ☐ Remove unnecessary alcohol-related questions
  - ☐ Remove prompts for patients around scoring thresholds
- ☐ Check you are using correct scoring thresholds
- ☐ Ensure that a clear alcohol DES pathway is in place & understood by staff
- ☐ Ensure that all scores are recorded on patient records via coding & that all positive scores are acted upon appropriately
- ☐ Debrief staff about the need to screen re-registering patients who have not been previously screened

STEP 3 BRIEF ADVICE

- ☐ Brief Advice training for key practitioners
- ☐ Use a standardised & localised Brief Advice tool
- ☐ Always give the Brief Advice tool to the patient
- ☐ Consider possibility of offering face-to-face Brief Advice
- ☐ Where Brief Advice is not successful, offer further in-house support & consider referral

STEP 4 EXTENDED INTERVENTION

- ☐ Ensure that all patients scoring at Higher Risk receive Brief Advice as a minimum
- ☐ Ensure that your practice pathway considers the needs of Higher Risk drinkers
- ☐ Consider the options for offering Extended Brief Interventions (EBI)
- ☐ Use a recognised EBI tool
- ☐ Where EBI is not successful, consider referral to your local community alcohol service
- ☐ Where consent has been given, communicate with the local alcohol service about referred patients

STEP 5 REFERRAL

- ☐ Referral to be offered to all patients scoring 20+ on AUDIT
- ☐ Where referral is refused, offer in-house support & engagement to High Risk/possibly dependent patients
- ☐ All high scores (AUDIT 16+) must be flagged to GPs
- ☐ Where consent has been given, communicate with the local alcohol service about referred patients

STEP 6 CODING

- ☐ Rationalise alcohol DES coding
- ☐ Debrief staff responsible for inputting codes
- ☐ Do a manual search to check your annual returns

Step 1 Training

Checklist
☐ On-going Identification & Brief Advice (IBA) training programme for clinical & administrative staff
☐ All staff conducting IBA to complete e-learning module as a minimum

On-going Identification and Brief Advice (IBA) training programme

IBA training for all staff involved in IBA (from administrative to clinical) is crucial to **improve consistency of your returns** and the **quality of the service your practice offers to patients** drinking above recommended limits.

IBA training should cover **the "nuts and bolts" of using screening and Brief Advice tools, including role plays; the barriers and challenges of IBA; pathways into support; and the principles and theories behind IBA, such as Motivational Interviewing**. Ideally an alcohol specialist with experience of IBA work should deliver IBA training. Where this is not possible, a debrief by a commissioner would be of use.

Annual training is **particularly important for practitioners delivering Brief Advice and/or Extended Brief Interventions (EBI)**, since these interventions, particularly EBI, involve techniques and theories that practitioners will need to revisit to **refresh** their knowledge. **IBA training can be sought from your local PCT, DAAT/Public Health Directorate or community alcohol service**.

All staff conducting IBA to complete e-learning module as a minimum

It is considered best practice for all practitioners involved in conducting IBA to complete the IBA e-learning module, endorsed by the **Royal College of General Practitioners (RCGP)** and **Royal College of Nursing (RCN)**.

It is important to recognise, however, that this online training is **not considered sufficient** standalone IBA training. The e-module ***does not cover*** the key operational issues. It is vital that these aspects are covered in a face-to-face training session that include **role-plays** to build practitioner's skills and experience.

The e-learning module can be accessed free of charge on the **Alcohol Learning Centre** website:

http://www.alcohollearningcentre.org.uk/eLearning/IBA/

All individuals who complete the module will receive an e-certificate and a grade as proof of completion.

BEST PRACTICE EXAMPLE 1
Newham PCT include completion of the IBA e-learning as a prerequisite for participation in their LES. This is a cost-neutral means of ensuring a minimum standard of training for IBA practitioners.

Step 2 Screening

Checklist

- ☐ Decide when & how to screen
- ☐ Review & revise your registration form
  - ☐ Check carefully whether you are using the correct AUDIT-C, FAST & AUDIT questions
  - ☐ Ensure that the relationship between initial screens (AUDIT-C & FAST) and AUDIT (full screen) is understood within your practice
  - ☐ Add a clear unit guide (where patients self-complete)
  - ☐ Remove unnecessary alcohol-related questions
  - ☐ Remove prompts for patients around scoring thresholds
- ☐ Check you are using the scoring thresholds
- ☐ Ensure that a clear alcohol DES pathway is in place and understood by staff
- ☐ Ensure that all scores are recorded on patient records via coding & that all positive scores are acted upon appropriately
- ☐ Debrief staff about the need to screen re-registering patients who have not been previously screened

Decide when and how to screen

Practices taking part in the DES have taken different approaches to screening new registrations. As a practice, there are various options for you to consider:

Screening Option 1

See Pathway Example A on pg 15

Integrate AUDIT-C (3 questions) or FAST (1-4 questions) and a unit guide into registration form completed by all new patients (16+).

Where a patient scores positively (5 or more on AUDIT-C and 3 or more on FAST), a follow-up full screen using the remaining 7 AUDIT questions (either by a practitioner or paper-based) should then be done.

Advantages:

- Where follow-up screen using full AUDIT is practitioner-led, this improves reliability of scores and allows the appropriate intervention to be delivered immediately.

Disadvantages:

- Arranging full AUDIT screens for all positive initial screens can be time-consuming and difficult, and can lead to low level of AUDITs completed.
- Patient's lack of understanding of units can lead to under- and over- reporting.
- Patients have more time to decide whether to be truthful about their drinking.
- Where registration form is paper-based, coding & arranging interventions can get overlooked unless there are clear lines of responsibility.

Screening Option 2

See Pathway Example B on pg 16

Integrate full AUDIT (10 questions) into a registration form completed by all new patients (16+) (See Appendix B for an example registration form using full AUDIT)

An administrator or practitioner responsible for checking the scores will then need to ensure that patients who scored positively (8 or more) get the appropriate intervention. This would mean either posting a Brief Advice leaflet to patients scoring 8-19 or preferably booking in an appointment with HCA or nurse. For patients scoring 20+, the administrator or practitioner responsible would then arrange an appointment with

their doctor to discuss referral into specialist treatment.

Advantages:

- Intervention can be arranged on receipt of registration form.

Disadvantages:

- Patient's lack of understanding of units can lead to under- and over- reporting.
- Patients have more time to decide whether to be truthful about their drinking
- Where registration form is paper-based, coding & arranging interventions can get overlooked unless there are clear lines of responsibility.

Screening Option 3

See Pathway Example B on pg 16

Integrate AUDIT (10 questions) screening into new patient health check conducted by a Practice Nurse or Healthcare Assistant for all new patients (16+).

This is the preferred model. A practitioner screens all patients using AUDIT-C and where patient scores positively, the remaining AUDIT questions should be asked, and the appropriate intervention delivered, or arranged, immediately.

Advantages:

- Face-to-face screening allows practitioners to calculate unit intake exactly (often through asking further questions around intake and frequency) and minimises under-reporting as a result.
- Brief Advice can be delivered immediately within the consultation. It is considered best practice to deliver these interventions as soon as possible after screening as much of their impact hinges upon the "teachable moment" created by "feeding back" the score.
- Smoother pathway both for practices and patients.

Disadvantages:

- Dependent on capacity within practice.
- Requires some training for practitioners who will be doing screening and delivering interventions.

Review and revise your registration form

Whichever option you choose for your practice, it is vital that you review and revise your registration forms and the screening tools used. Follow the steps outlined below:

Check carefully whether you are using the correct AUDIT-C, FAST and AUDIT questions

The most up-to-date versions can be found on the Alcohol Learning Centre and Primary Care Commissioning websites. See below in **BOX 1, 2 and 3** for the most up-to-date versions at time of publication.

- Check carefully that your versions of the questionnaires ask patients about how many **units** they drink not how many **drinks**. ***A "drink" can have any number of units in it.***

Ensure that the relationship between initial screens (AUDIT-C & FAST) and AUDIT (full screen) is understood within your practice

The **Alcohol Use Disorders Identification Test (AUDIT)** is a **ten-item alcohol screening questionnaire** developed by the **World Health Organisation (WHO)** and endorsed by the **Department of Health**. AUDIT is considered the **"gold standard"** for alcohol screening and has **high rates of specificity and sensitivity** (Saunders et al 1993). **AUDIT-C (BOX 1)** and **FAST (BOX 2)** are modified, shortened versions of AUDIT created for busy clinical settings in order to do an **initial screen**.

AUDIT-C and FAST are, however, only **initial screens**. Where a patient scores positively on AUDIT-C or FAST, **a full AUDIT must be completed (i.e. the remaining questions of AUDIT asked) and the scores for all ten questions totaled**.

We highly recommend using AUDIT-C as your initial screen because the first three questions of AUDIT-C are Questions 1-3 of AUDIT, so doing a full AUDIT just means asking the remaining seven questions (Questions 4-10). FAST, on the other hand, is made up of Questions 3, 8, 5, and 10 of AUDIT, and so full AUDIT screening means asking Questions 1, 2, 4, 6, 7, 9 and 10.

BOX 1 AUDIT-C

AUDIT-C Questions	Scoring system					Your score
	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking? *(See unit guidance below/above.)*	1 -2	3-4	5-6	7-9	10+	
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL _____	

AUDIT-C is a **three-item alcohol screening questionnaire** that can help identify people drinking above recommended limits. The AUDIT-C is a modified version of the ten-question AUDIT designed to be quicker and easier to use. **Where a patient is AUDIT-C positive, the remaining AUDIT seven questions should be asked and the scores from this and AUDIT-C totaled**.

AUDIT-C is the author's **preferred initial screening tool** because it is made up of Questions 1-3 of AUDIT and so a full AUDIT screen only entails asking Questions 4-10 and totaling the scores.

BOX 2 FAST

FAST Questions	Scoring system					Your score
	0	1	2	3	4	
1. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? *(See unit guidance below/above.)*	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Monthly (2) or Less than monthly (1). Stop here if the answer is Never (0), Weekly (3) or Daily (4). **If total FAST score is 3 or more, patient is FAST positive.**						
2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
3. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. Has a relative or friend, doctor or health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL _____	

FAST is a **four-item screening questionnaire** developed for busy clinical settings using four questions from the **Alcohol Use Disorder Identification Test (AUDIT**). FAST is a two-stage screening test that is quick to complete, since **more than 50% of patients will be identified by Question One**. **Where a patient is FAST positive, the remaining AUDIT questions should be asked and the scores from this and FAST totaled**.

BOX 3 FULL AUDIT

	Scoring system					Your score
	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking? *(See unit guidance below/above.)*	1 -2	3-4	5-6	7-9	10+	
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
						TOTAL _____
	Scoring system					
	0	1	2	3	4	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
						TOTAL _____

The **Alcohol Use Disorders Identification Test (AUDIT)** is a **ten-item alcohol screening questionnaire** developed by the **World Health Organisation (WHO)** and endorsed by the **Department of Health**. AUDIT is considered the **"gold standard"** for alcohol screening and has the **high rates of specificity and sensitivity** (Saunders et al 1993).

Add a clear unit guide (where patients self-complete)

If you don't provide one already, then integrate a unit guide into your registration form adjacent to the questions about unit consumption, so that patients can calculate their consumption accurately. See **FIG. 1** below for an example of a clear unit guide that is both visual and text-based, and see **Appendix B** for an example of how you might integrate a unit guide into your registration form.

FIG. 1 Unit Guide

Remove any unnecessary alcohol-related questions

Remove any unnecessary, vague or unhelpful questions about alcohol—**"Do you drink alcohol?"** or **"How many alcoholic drinks do you drink in a week?"**—from your registration process. Using the **standard alcohol screening questions** (i.e. AUDIT-C, FAST and AUDIT) will capture **all you need to know about a patient's drinking**, while also ensuring that you **fulfil the requirements of the alcohol DES**.

Where screening tools are self-completed, **remove any prompts to patients around the scoring thresholds**—i.e. **"A score of 5+ indicates possible Increasing or Higher Risk drinking"**—as this can lead patients to under-report, so as not to score at a level that triggers further intervention.

Check you are using the correct scoring thresholds.

See **BOX 4** below for the correct scoring thresholds.

BOX 4 SCORING THRESHOLDS

AUDIT-C

Below 5	**No action required except coding on record.**
5 or above	**Complete full AUDIT questionnaire with patient & code on record.**

FAST

A score of 0 on the first question indicates FAST negative.
A total of 1 – 2 on the first question, then continue with the next three questions.
A total of 3 – 4 on the first question, stop screening at first question.
An overall total score of 3 or above is FAST positive.

Where FAST positive	**Complete full AUDIT questionnaire with patient & code on record.**
Where FAST negative	**No action required except coding on record.**

AUDIT

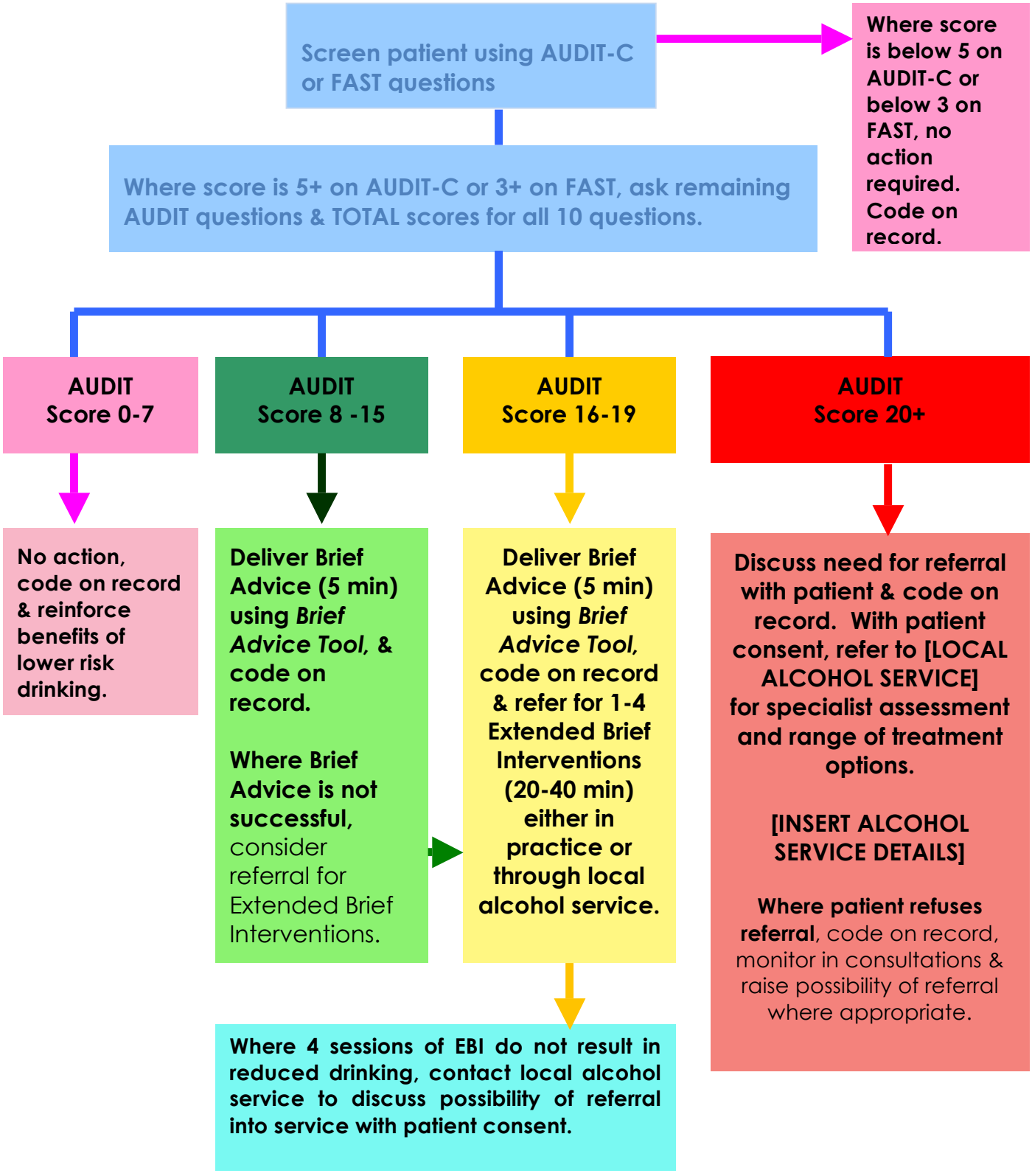
0 –7	**Lower Risk**	**No action required except coding on record.**
8 –15	**Increasing Risk**	**Deliver Brief Advice, code on record and alert GP.**
16 –19	**Higher Risk**	**Deliver Brief Advice, offer Extended Brief Intervention appt, code on record and alert GP.**
20+	**High Risk**	**Referral to local alcohol service for specialist support, code on record, and book appointment with GP to discuss referral.**

Ensure that a clear alcohol DES pathway is in place and understood by staff

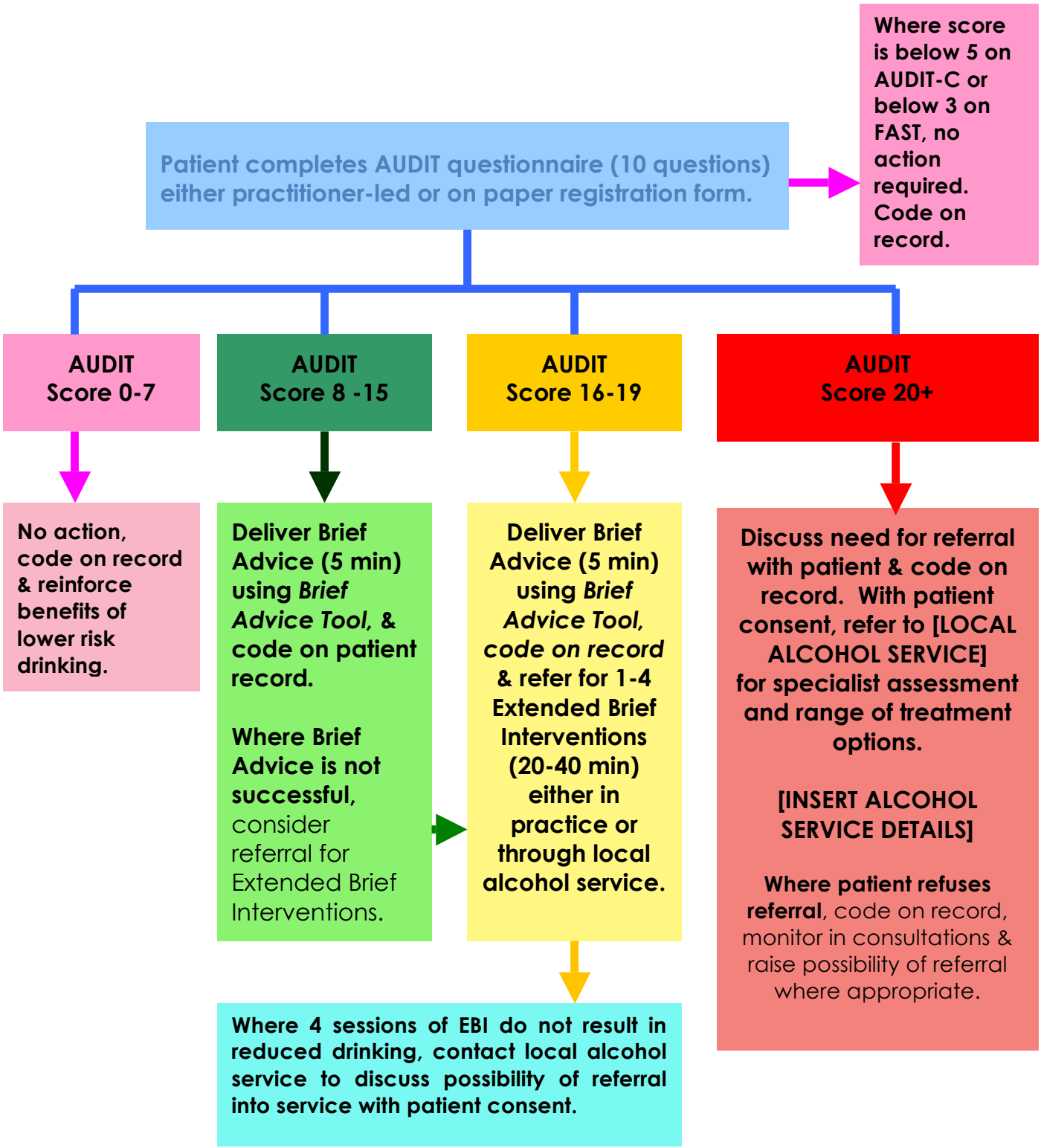
One the easiest ways to ensure that the alcohol DES works well in your practice is to **develop an agreed alcohol DES pathway** and **debrief your team (clinical and administrative) on how the pathway works**.

Your practice pathway will **depend on the decisions you made earlier (on pages 9-13) about which screening tool to use and how to deliver the various interventions**. See below for two examples.

PATHWAY EXAMPLE A **AUDIT-C or FAST Pathway**



PATHWAY EXAMPLE B **AUDIT Pathway**



- **Ensure that all scores are recorded on patient records via coding and that all positive scores are acted upon appropriately**.

  Where score is 8-15, deliver Brief Advice, and record their score and code for Brief Advice on IT system.

  Where score is 16-19, deliver Brief Advice, record their score and code for Brief Advice on IT system, and consider the possibility of offering **Extended Brief Intervention** (EBI) either in-house or via referral to the local alcohol service. At the very least, alcohol use should be addressed where appropriate during the patient's next consultation. Where Brief Advice is not successful or EBI is not available within the practice, a medical practitioner should discuss referral to a specialist alcohol service with the patient.

  Where score is 20+, their score should be coded and an appointment should be booked with a medical practitioner as soon as possible to discuss referral for specialist alcohol treatment or shared care (where available). Referral should then be made (subject to patient consent).

- **Debrief staff about the need to screen re-registering patients who have not been previously screened**

  Of the surgeries that we reviewed, **none had a system in place to screen re-registrations**. This was significantly **skewing the percentage of registrations that they were screening**.

  Implement a system whereby a patient who re-registers but has not been previously screened is screened on re-registration or your practice will **report low screening numbers** and **miss the financial incentives**.

BEST PRACTICE EXAMPLE 2 A Model Process (as operating in Allenson House Medical Centre, Haringey)

- All new patients booked for 20-minute appointment with the Nurse in which general health (i.e. diet, smoking, and alcohol) are discussed.
- Nurse screens using AUDIT-C.
- Where score is 5 or above on AUDIT-C, Nurse screens using full AUDIT.
- Where AUDIT score is 8-15 (Increasing Risk), the Nurse delivers Brief Advice using a Brief Advice tool, which is given to patient at the end.
- Where AUDIT score is 16-19 (Higher Risk), the Nurse gives some Brief Advice, an Extended Brief Intervention appointment is booked with the Nurse, and a flag is put in the patient record to highlight that this patient's drinking should be monitored.
- Where AUDIT score is 20+ (High Risk/possibly dependent), referral to a specialist alcohol service is discussed, a note is put on file to pop up and Nurse discusses high score with GP.
- GP looks at all new patient registrations, especially if any medical history. If there are any alcohol/substance misuse concerns, patient is called in for a review.
- All positive AUDIT scores are discussed by the Nurse and GP.
- Nurse inputs clinical data and coding on to data system.
- Monthly check of results by Practice Manager and Nurse during which coding anomalies are addressed, and need for further intervention reviewed or organised.
- Practice Manager collates annual returns by using a manual search on the practice system.

Step 3 Brief Advice

Checklist
☐ Brief Advice training for key practitioners
☐ Use a standardised & localised Brief Advice tool
☐ Always give the Brief Advice tool to the patient
☐ Consider the possibility of offering face-to-face interventions
☐ Where Brief Advice is not successful, offer further in-house support & consider referral

Brief Advice training for key practitioners

Brief Advice training should **cover key factual information**—about units, limits, risks and how to reduce—and build practitioner's skills in delivering **motivational work**.

Regular IBA and **Motivational Interviewing (MI)** training is therefore essential to ensure the efficacy of the interventions delivered in your practice.

See **Step 1 Training** for more information around training your practice staff.

Use a standardised and localised Brief Advice tool

It is crucial that local areas create use locally relevant versions of standard Brief Advice tools to improve alcohol DES delivery. These need to be simple and short; deliver basic information on units, risks, benefits of cutting down and tips for cutting down; provide space for making a reduction plan; and give local service information. These tools are interventions in themselves and should be given to the patient so that they can refer to their reduction plan.

You can download the NHS Brief Advice tool here: **http://www.pcc.nhs.uk/alcohol**

In Haringey, we have adapted this tool by integrating local information, adding more unit information, and explaining the types of support available for Increasing Risk, Higher Risk and High Risk/possibly dependent drinkers (**Appendix C**). To download the latest version of our tool, visit **http://www.haga.co.uk/Tools.htm** and click on **Alcohol DES Brief Advice Tool**. We have left spaces for you to insert locally relevant contact information, so it should take just a few minutes to develop your own local Brief Advice tool for use in your surgery or across your region.

Always give the Brief Advice tool to the patient

The Brief Advice tool **is an intervention in itself**. If they don't change now, they might change later. Many patients will read the leaflet in their own time, or, where there are literacy problems, they may ask a friend or relative to help them translate it.

Consider the possibility of offering face-to-face interventions

It is widely acknowledged that results are better where **face-to-face interventions** with an experienced practitioner are offered. HCAs and Nurses are most frequently identified as suitable for delivering 1:1 Brief Advice and Extended Brief Interventions.

Where Brief Advice is not successful, offer further in-house support & consider referral

A "stepped care" treatment model starts patients at the **lowest appropriate intervention in the first instance** and **"steps up" to more intensive or specialist services as clinically required**.

Brief Advice is a one-off intervention. Where Brief Advice has not been successful in reducing a patient's drinking, **up to four Extended Brief Intervention sessions should be offered as a follow-up**. **Where the EBI has not been effective, longer-term specialist treatment options should be explored** with the patient and the local alcohol treatment provider.

Step 4 Extended Intervention

Checklist
☐ Ensure that all patients scoring at Higher Risk receive Brief Advice as a minimum
☐ Ensure that your practice pathway considers the needs of Higher Risk drinkers
☐ Consider the options for offering Extended Brief Interventions
☐ Use a recognised EBI tool
☐ Where EBI is not successful, consider referral to your local community alcohol service
☐ Where consent has been given, communicate with the local alcohol service when a patient has been referred

Ensure that all patients scoring at Higher Risk receive Brief Advice as a minimum

In line with **best practice**, all patients scoring at Higher Risk levels should receive Brief Advice **as a minimum**.

Ensure that your practice pathway considers the needs of Higher Risk patients

Whilst Brief Advice will be successful in helping some Higher Risk patients to reduce their drinking to within Lower Risk levels, some patients will need further support in the form of Extended Brief Interventions. **Extended Brief Interventions (EBI)**, also known as **Brief Lifestyle Counselling**, are 20-40 minute sessions based on the therapeutic principles of **health behaviour counselling** (e.g. Rollnick et al. 1999) and **Motivational Interviewing (MI)**. EBI is offered after Brief Advice to patients who:

- have an AUDIT score 16-19
- and/or failed to benefit from Brief Advice (see page 19)
- and/or request further support with their drinking
- and/or in the practitioner's view, need further help to improve
- and/or are ambivalent about the need for changing their drinking
- and/or patient is highly motivated to change their drinking

Unlike Brief Advice, EBI generally requires **follow-up appointments (up to four)** to embed behaviour change. EBI aims to support the individual in achieving Lower Risk drinking or abstinence. Delivering EBI requires **more intensive training** and **clinical experience** than Brief Advice.

There is as yet an inconclusive evidence base supporting the efficacy of EBI. The evidence as it stands suggests that Brief Advice can be as effective as these longer more therapeutic sessions. However, where an individual meets one or more of the criteria above, EBI fills a vital role in delivering support for Higher Risk drinkers (and some High Risk drinkers) on the principle of "stepped care." For further debate, see Alcohol Academy 2010.

Consider the options for offering Extended Brief Interventions

Capacity issues make the delivery of EBI in primary care difficult. Practices will need to be creative if they are to offer interventions of this level. The options include:

- EBI training for HCA and Practice Nurses who could then deliver EBI to all Higher Risk patients in specially-booked appointments.
- Satellite service by local alcohol service in which Higher Risk and High Risk patients could be booked appointments, where they have the capacity to offer EBI or specialist assessment.
- Referral to your local alcohol service (where they have capacity to support Higher Risk drinkers).

Use a recognised EBI tool

As with Brief Advice, there are evidence-based tools available to assist practitioners in delivering EBI. The most up-to-date EBI tool is the **Screening and Intervention Programme for Sensible Drinking (SIPS)** project's **Brief Lifestyle Counselling Tool**, which can be downloaded from their website: **http://www.sips.iop.kcl.ac.uk/blc.php**

Where EBI is not successful, consider referral to your local community alcohol service

Where four EBI sessions have not led to a reduction in drinking, consider **referral** to your local community alcohol service for **specialist treatment options**.

Where a patient refuses referral, practitioners should **monitor their drinking** and **readdress the possibility of referral as appropriate**. Primary care practitioners can also contact their local alcohol service for advice on **how to motivate patients to access treatment** and for **practical information on harm minimisation**.

Where consent has been given, communicate with the local alcohol service about referred patients

Whenever an individual has been referred into specialist alcohol treatment, there should be **on-going communication** between the local alcohol service and their GP regarding **patient progress** (where **consent** has been given by the patient to do so).

BEST PRACTICE EXAMPLE 3

Some GP practices opt to train their HCAs or Practice Nurses in the delivery of EBI and book appointments for all patients scoring at these levels.

Some practices work with local alcohol services to offer satellite alcohol clinics in surgery for High and Higher Risk patients. These satellites provide easy access to EBI and higher threshold treatment options, and reduce the stigma typically felt to be associated with attending an alcohol service.

Step 5 Referral

Checklist
☐ Referral to be offered to all patients scoring 20+ on AUDIT
☐ Where referral is refused, offer in-house support & engagement to High Risk/possibly dependent patients
☐ All high scores (AUDIT 16+) flagged to GPs
☐ Where consent has been given, communicate with the local alcohol service about referred patients

Referral to be offered to all patients scoring 20+ on AUDIT

It is essential that referral is offered to all patients scoring 20+ on AUDIT. Patients drinking at High Risk levels will already have **experienced harm as a result of their drinking** and are **likely to be alcohol dependent**. Alcohol dependence is the result of **high alcohol consumption** that leads to dependence associated with a range of **physical and psychological withdrawal symptoms** when alcohol consumption is ceased or substantially reduced. High Risk drinkers **typically require specialist alcohol treatment**, such as **detoxification and/or psychosocial interventions**, in order to reduce or cease their drinking.

In 2009-2010, **only 10 individuals** were referred to Haringey's local alcohol service as a result of new patient screening under the alcohol DES.

Ensure that your practice has a clear pathway into support for High Risk/possibly dependent drinkers.

Where referral is refused, offer in-house support & engagement to High Risk/possibly dependent patients

Where a patient refuses referral, practitioners should **monitor their drinking** and **readdress the possibility of referral as appropriate**.

Primary care practitioners can **contact their local alcohol service** for **advice on how to motivate patients to access treatment** and for **practical information on harm minimisation**.

All high scores (AUDIT 16+) must be flagged to the GPs, so that they can be discussed during consultation and that active attempts can be made by practitioners to refer the Higher Risk (AUDIT score 16-19) and possibly dependent (AUDIT score 20+) patients into specialist treatment.

When we reviewed local surgeries, many participating GPs were concerned to realise that they had not been checking these scores in consultation or considering the pathway into support for high-scoring patients.

Participating practices in Haringey are now either recording high scores as **ACTIVE CONDITIONS** or, in Vision practices, putting "**STICKIES**" to highlight them on the patient record.

One local practice, **Duke's Avenue Practice**, now ensures that the **Practice Manager communicates with medical staff regarding all high-scoring patients**.

- **Where consent has been given, communicate with the local alcohol service about referred patients**

  Whenever an individual has been referred into specialist alcohol treatment, there should be **on-going communication** between the local alcohol service and their GP regarding **patient progress** (where **consent** has been given by the patient to do so).

Step 6 Coding

Checklist
☐ Rationalise alcohol DES coding
☐ Debrief staff responsible for inputting codes
☐ Do a manual search to check your annual returns

Rationalise alcohol DES coding

Review your DES coding with reference to the most recent DES guidance (NHS & BMA 2011) and the IT templates available on the Alcohol Learning Centre website, and rationalise your alcohol read codes.

For IT templates, click on the link below:
http://www.alcohollearningcentre.org.uk/Topics/Browse/PrimaryCare/GPTemplates/

Concept	Action	4 BYTE	V2	V3	SCT
FAST Alcohol Screening Test	Already exists	388u.	388u.	XaNO9	303471000000106
AUDIT–C Alcohol Screening Test	Already exists	.38D4	38D4.	XaORP	335811000000106
AUDIT Alcohol Screening Test	Released April 2008	38D3	38D3	XM0aD	273265007
Brief Intervention for excessive alcohol consumption completed	Released April 2008	9k1A	9k1A	XaPPv	366371000000105
Extended Intervention for excessive alcohol consumption completed	Released April 2008	9k1B	9k1B	XaPPy	366421000000103
Referral to Specialist Alcohol Treatment Service	Released April 2008	8HkG.	8HkG.	XaORR	431260004

TABLE 1. Current Alcohol Read Codes (NHS & BMA 2011)

There are some anomalies. For example, there are currently no codes available which indicate a positive FAST or AUDIT-C test result, so it will be necessary to add a value to a field associated with the code. Consult the most recent DES guidance and your computer system supplier for further details.

Debrief all staff responsible for inputting codes to ensure that screening and interventions are being coded correctly throughout the year, and all work completed by the practice is rewarded at the end of the financial year. Make sure you have a clear list of alcohol read codes in use within the practice. Ensure in particular that staff know that scores of zero should still be coded (see **Page 36**).

Do a manual search to check your annual returns to ensure all patients who were screened are included in your return and your practice is duly rewarded. Contact your local DAAT, Public Health Directorate or PCT for assistance in this area.

II Background

Before we look in more detail at our review and our recommendations, some readers may be interested in the background to the introduction of IBA into primary care.

Identification and Brief Advice (IBA)

Identification and Brief Advice (IBA) is a process that involves practitioners using a **screening tool** to identify people **drinking at risky levels** and then delivering the appropriate level of intervention, from **five minutes** of **Brief Advice** to **referral for specialist treatment**.

IBA has an **extensive evidence base**, including over 100 studies in the last forty years. IBA is most well evidenced in **primary care settings**. Since the 1970s, IBA has been consistently validated in primary care and, to a lesser extent, in A&E and hospital, settings (Heather et al 1987; Wallace et al 1988; Anderson & Scott 1992; Babor & Grant 1992; WHO 1992; WHO 1996; Gentilello et al 1999; Ockene et al 1999; Poikolainen 1999a & 1999b; Nilsen et al 2008). Meta-analytic reviews have corroborated this research (Bien et al 1993; Wilk et al 1997; Moyer et al 2002; Kaner et al 2007). One hugely influential review of **thirty-two controlled trials** concluded that **one in every eight individuals who is screened and receives Brief Advice will reduce to within Lower Risk levels** (Moyer et al 2002).

Recent guidance from the **National Institute of Clinical Excellence (NICE)** *Alcohol-use disorders: preventing the development of hazardous and harmful drinking (2010)* recommends **the delivery of IBA in primary care and other settings *as standard*.**

Local Enhanced Services (LES)

Following the ***Alcohol Harm Reduction Strategy for England* (2004)**, **alcohol-focused Local Enhanced Services (LES)** were set up across the country with local practices. An alcohol LES is a package targeted at meeting the needs of the local population, most often involving **screening existing patient lists** and **delivering Brief Advice**. Payment packages are locally agreed.

Direct Enhanced Service (DES)

Building on the thinking behind LES delivery, in April 2008, **NHS Employers** and the **General Practitioners Committee (GPC)** of the **British Medical Association (BMA)** agreed **five new clinical Directed Enhanced Services (DES)**; one of which was a DES specification for alcohol. Under the alcohol DES, practices are **financially rewarded** for **screening all new registrations aged 16 and over**. As part of the DES, practices **deliver Brief Advice to patients identified as drinking at Increasing and Higher Risk levels**. Following practice returns, payment is made annually to practices. The total investment for this DES in England in 2008/09 and 2009/10 was **£8m per year**.

The DES Guidance published in 2008 outlined the process for delivery (see **BOX 5**). At this stage, there was limited clarity around coding (i.e. five possible Read Codes were suggested for Brief Advice (5)).

BOX 5 Extract from initial guidance on DES process (NHS Employers & BMA 2008)

- **SCREENING USING AUDIT-C OR FAST**: Practices will be required to screen newly registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete.

- **SCREENING USING AUDIT**: If a patient is identified as positive, the remaining questions of the ten-question AUDIT questionnaire are used to determine Hazardous, Harmful or likely dependent drinking.

- **BRIEF INTERVENTIONS**: Following identification, the practice should deliver a brief intervention to those identified as drinking at Hazardous or Harmful levels. The recommended brief intervention is the basic five minutes of advice used in WHO clinical trial of brief intervention in primary care, using a programme modified for the UK context by the University of Newcastle, *How Much is Too Much?*

- **REFERRAL**: Dependent drinkers should be referred to specialist services.

- **ANNUAL RETURNS**: Practices will be required to provide an audit of:

  - the number of newly registered patients aged 16 and over within the financial year who have had the short standard case-finding test (FAST or AUDIT-C)
  - the number of newly registered patients aged 16 and over who have screened positive using a short case-finding test (as above) during the financial year, who then undergo a fuller assessment using a validated tool (AUDIT) to determine Hazardous, Harmful or likely dependent drinking
  - the number of Hazardous or Harmful drinkers who have received a brief intervention to help them reduce their alcohol-related risk
  - the number of patients scoring 20+ on AUDIT who have been referred for specialist advice for dependent drinking.

- **PAYMENT**: Payment will be made at the end of the year (31 March each year) following receipt by the Primary Care Trust (PCT) of the audit. Each year, practices will receive £2.33 for each newly registered patient aged 16 and over who have received screening using either FAST or AUDIT-C. It is expected that practices participating in this DES will respond to identified need and provide the intervention as required.

In May 2008, the ***Primary Care Service Framework: Alcohol Services in Primary Care*** guidance gave an overview, covering the process, tools, coding and best practice examples, alongside a suite of supportive resources. An **Alcohol Care Pathway for Primary Care** was also introduced (**FIG. 2**).

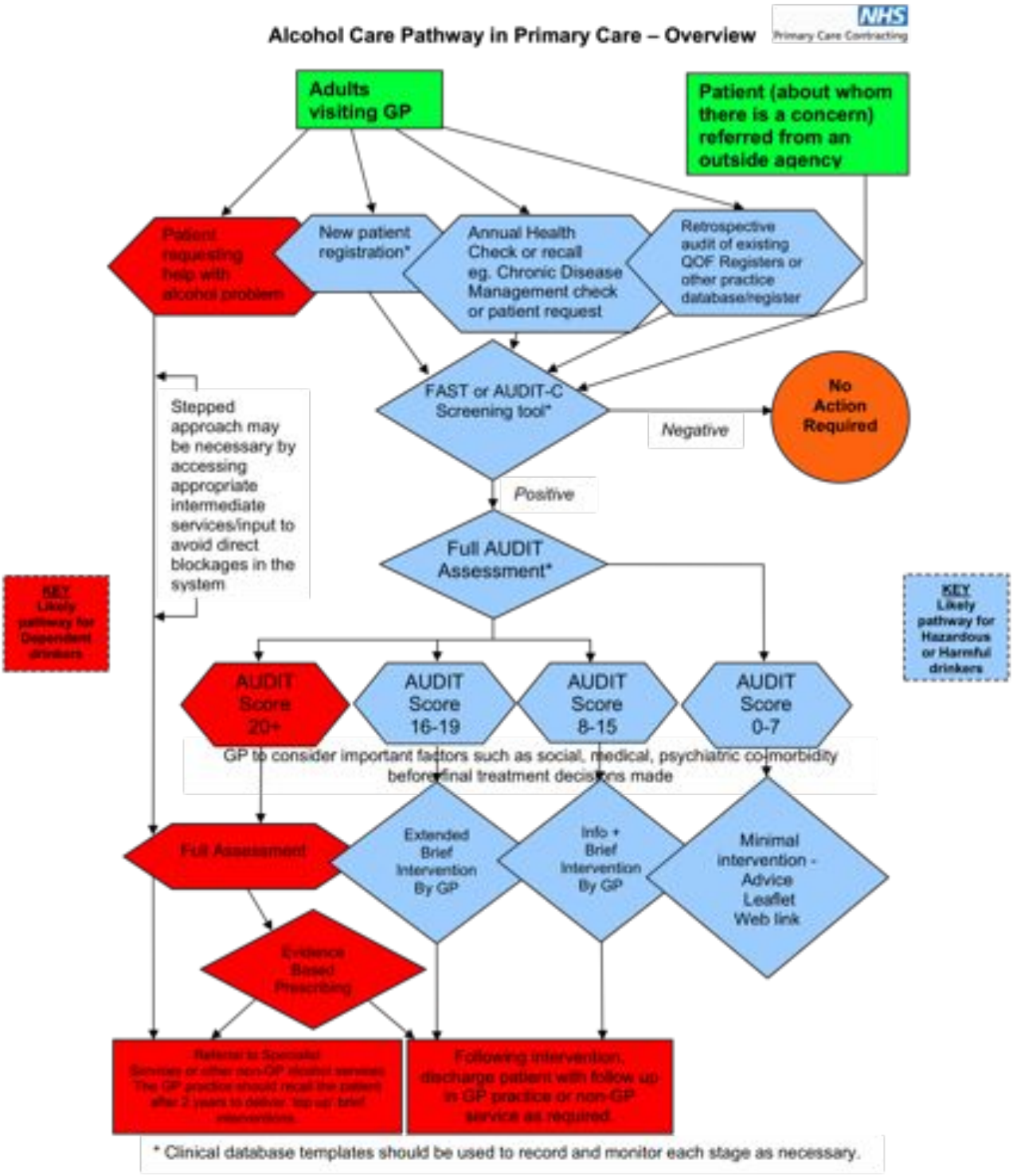


FIG. 2 Alcohol Care Pathway in Primary Care (NHS 2008)

In March 2009, NHS Employers & the BMA produced further guidance with more detailed information regarding coding, thresholds, and risk levels. An **updated Brief Advice tool** was introduced with this new guidance. Later that year, in May, **NHS Primary Care Contracting (PCC)** published a revised *Primary Care Service Framework: Alcohol Services in Primary Care*, which heralded **key changes in terminology towards risk-focused categories of drinker**. This followed a request from the **Chief Medical Officer (CMO)** to the **Department of Health and the NHS** that the terms "Lower Risk," "Increasing Risk" and

"Higher Risk" should be **used in key communications with the public (See TABLE 2)**. This change was a response to **reported confusion from the public and healthcare professionals about the existing language: "sensible", "Hazardous" and "Harmful."**

Previous Terminology	Revised Terminology	Unit-based definitions
Sensible	**Lower Risk**	For men: not regularly drinking > 3-4 units per day. For women: not regularly drinking > 2-3 units per day.
Hazardous	**Increasing Risk**	For men: regularly exceeding > 3-4 units per day but not drinking at levels incurring the highest risk. For women: regularly exceeding > 2-3 units per day but not drinking at levels incurring the highest risk.
Harmful	**Higher Risk**	For men: regularly exceed > 8 units per day or regularly drinking > 50 units per week. For women: regularly exceed > 6 units per day or regularly drinking > 35 units per week.

TABLE 2. Terminology Change (NHS Primary Care Contracting 2009)

In June 2009, a revised pathway, which usefully included Read Codes, was released by the Department of Health (**FIG. 3**). This had a misleading error; in that, an AUDIT score of 16-19 not 16-20 should prompt Extended Brief Intervention.

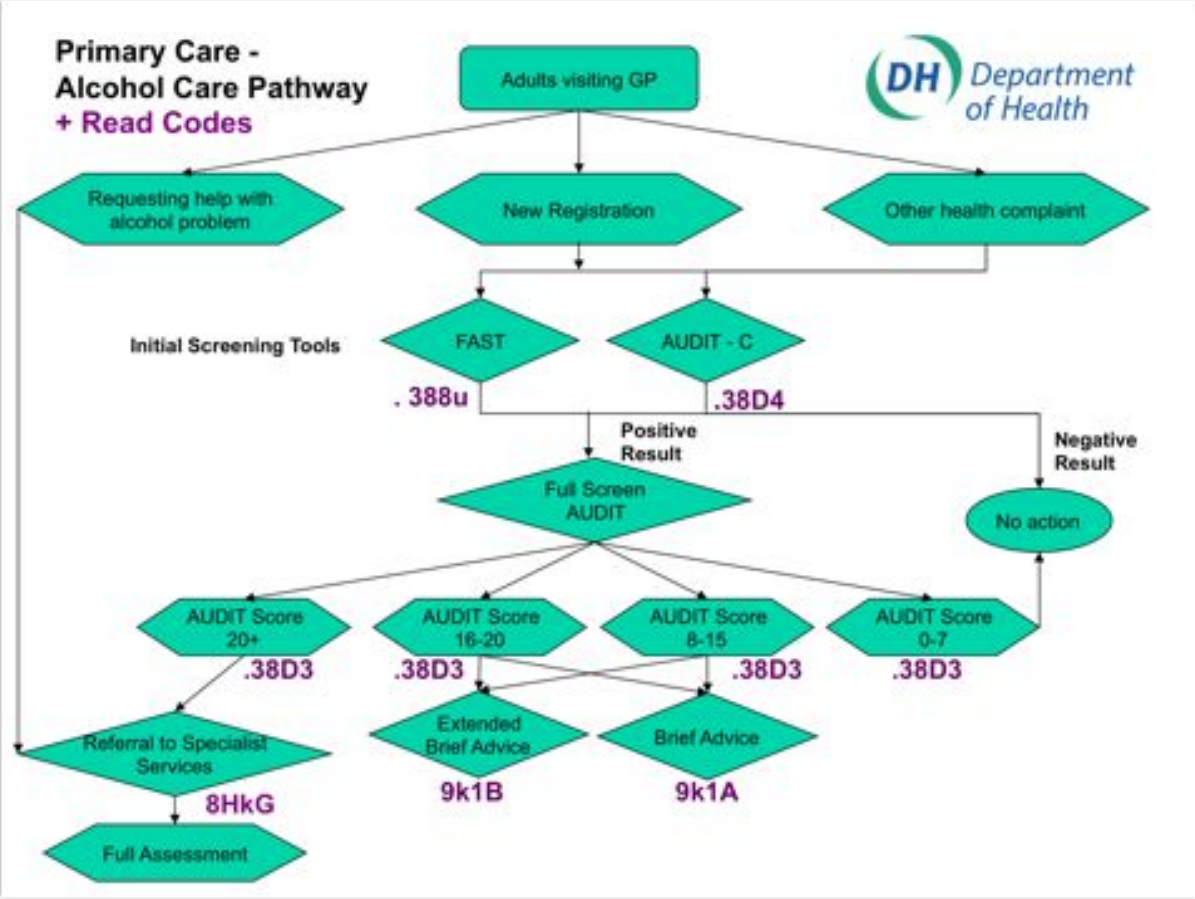


FIG. 3. Primary Care – Alcohol Care Pathway + Read Codes (Department of Health 2009)

In March 2010, NHS Employers and the BMA released new DES guidance for 2010-2011. Extended Brief Interventions were referred to here as **Brief Lifestyle Counselling** (reflecting the terminology used in Kings College London's collaborative study, Screening and Intervention Programme for Sensible Drinking (SIPS)). This document included comprehensive links to an extended suite of resources, including screening tools, Brief

Advice tools, and coding templates. Commissioners were advised of the new Department of Health Brief Advice tool and given links to the **Alcohol Learning Centre** website. In November 2010, a **revised Brief Advice tool** was released by the **Department of Health** and posted on the Alcohol Learning Centre website.

In March 2011, the alcohol DES was **extended for a further twelve months until March 2012**.

Summary

There has been a **concerted effort to support the implementation of the alcohol DES at a local level** through the provision of up-to-date screening tools, Brief Advice tools, recommended Read Codes, and IT templates. The Primary Care Commissioning "Alcohol" web page and the Alcohol Learning Centre website have been central to **disseminating new, emerging best practice alcohol DES information**.

However, those practices that began the alcohol DES in 2008 may not have read subsequent guidance and consequently missed refinements and changes to process, tools and terminology. These **changes in terminology, coding and to the AUDIT questions** will have hampered participating practices' understanding of the DES. Terminology in written guidance is moreover invariably different from that used on surgery IT systems (i.e. EMIS or VISION), and this has no doubt led to **confusion amongst medical and administrative staff.** Confusion was found at a local level in our review of Haringey DES practices; the findings of which can be found in **Section IV**.

III. DES Review

This section will primarily be of interest to **commissioners** interested in conducting their own alcohol DES review locally. Our review was cited as an example of **best practice** in *Intensive Support in Reducing Hospital Admissions* (2010), a report commissioned by the Department of Health's Regional Public Health Group.

Why review?

Haringey DAAT initiated the review of the alcohol DES due to their **concerns about the low screening, intervention and referral statistics locally**. In 2009-2010, **twenty-nine practices** delivered the alcohol DES locally.

- The percentage of new registrations varied widely from **24% to 100%,** with a borough-wide average of 79%.

- The **levels of risk identified did not match local or national prevalence estimates for risky drinking.**

  For example, **one practice screened 100% of new registrations and of these 100% screened positive on AUDIT and required Brief Advice**.

  Seventeen practices (well over 50%) identified **no patients as positive on AUDIT** (i.e. all their new patients were abstainers or Lower Risk drinkers).

  Only two practices reported screening outcomes that were at the level we would expect (i.e. 25-30%).

  Across twenty-nine practices, only 2% of patients screened positive and required Brief Advice or referral from April 2009 to March 2010.

- **It is of serious concern that only ten patients were referred for specialist alcohol treatment as a result of alcohol DES screening during this period across the borough**.

Purpose of the Review

- To understand the reasons behind the wide range of screening outcomes reported by participating local practices
- To identify areas where practices need additional support and training and organise a programme of 1:1 training at practice level

Review Design

A **Steering Group** of interested professionals was set-up to plan the review: this consisted of **an Independent Consultant representing Haringey DAAT**, responsible

for planning and conducting the review; the **C.E.O, HAGA, a community alcohol service**; the **Brief Interventions Specialist, HAGA**, responsible for assisting in planning and conducting the review; and the **Joint Commissioner for Drug and Alcohol Services, Haringey DAAT**, responsible for leading the Steering Group.

The Steering Group considered a number of **review approaches**, including sending questionnaires to all practices; phone calls with selected practices; group meetings; and on-site reviews.

It was agreed that a questionnaire or telephone survey would be difficult for busy practices to give due attention to and would not allow for in-depth discussion about any issues that might arise. It was also speculated that since various people within each practice—i.e. Receptionists, Healthcare Assistants, Practice Nurses, GPs, and the Practice Manager—lead on different areas of delivering the alcohol DES—i.e. inputting data, conducting screening, delivering interventions, and collating returns—the results of any remotely conducted survey would only capture the views and experience of the staff member designated to take the call or complete the survey. Group meetings would similarly capture only the views of those represented at the meeting, whilst also being difficult and expensive to organise, due to the need for locum cover. It was therefore agreed that an **on-site review** at selected surgeries would give the most detailed picture of local alcohol DES processes.

Approval was sought and received from the **Local Medical Committee (LMC)** and the purpose of the review was presented to each of the four collaboratives in the borough.

Identifying Practices

The Steering Group wanted to identify practices that were representative of the range of different alcohol DES returns reported by practices.

The Steering Group organised **screening ratios** for each practice according to the proportion of patients who:

- **were screened using AUDIT-C**
- **screened negative on AUDIT-C**
- **screened positive on AUDIT-C and screened using full AUDIT**
- **screened at Increasing and Higher Risk level and received Brief Advice**
- **referred to specialist alcohol service**

On the basis of this data, it was clear that practices fell into **three broad groups**:

1. **Practices identifying a high proportion of patients who were screened as "at risk"**
2. **Practices screening a high proportion of patients but finding none or very few to be "at risk"**
3. **Practices screening a low proportion of patients**

On the basis of this analysis, the Steering Group identified two practices from each of the three groups and approached them to participate in the review.

The review was conducted with **four practices** that had a range of results.

Practice Review

A structured questionnaire was developed to guide the discussion with each practice (see **Appendix A or download from www.haga.co.uk/Tools.htm**). From the section "**Alcohol DES Guidance Tools for Primary Care**."

The **Alcohol DES Practice Review Sheet** was organised into the following sections:

1. **Collating Information for the DES Return**: To ascertain whether the process used to collect data for the return produced accurate or inaccurate data
2. **Recording Screening Information:** To ascertain whether screening results have been accurately coded via a search of ten randomly selected records of new registrations not coded as screened (i.e. no AUDIT score).
3. **Alcohol Screening, Intervention and Referral process:** To ascertain whether practices were screening, delivering interventions and referring as appropriate; and to thereby support the DAAT to identify training gaps.

Practice Visits

The **Review Team** consisted of the Independent Consultant and HAGA's Brief Interventions Specialist. The team visited four practices during September and October 2010. These visits involved consultation with the **Practice Managers** at all practices and with the GP at one practice and a **Practice Nurse or Healthcare Assistant (HCA)** at two others. The team had planned to meet GPs from each practice but this was only possible in one surgery.

IV. Review Findings

This section will primarily be of interest to **commissioners**, **GP Partners** and **Practice Managers** as we outline here the findings of our review, which form the basis of the **Step-By-Step Guide** found in **Section I**.

Training

- **Only one of the four practices reviewed had received any IBA training to support delivery of the DES**.
  Many of the issues with delivery of the DES could be eliminated were practitioners and practice staff, especially Practice Managers, **regularly trained and updated on developments in best practice for IBA**.

Screening

- **Most practices were using incorrect screening questions or scoring thresholds.**
  In our localised review, **three out of four practices** were using screening questions that were incorrect. Practices were using the international WHO version of AUDIT that refers to "drinks" rather than the UK version that refers to "units." ***If this pattern is repeated across the country, then this will have significantly skewed reported screening outcomes.***

BOX 6 international vs UK AUDIT-C, FAST & AUDIT questions

For example, the international version of Question 2 of AUDIT-C and AUDIT reads:

*How many **drinks** do you drink on a typical day when you are drinking?*

The UK version reads:

*How many **units** of alcohol do you drink on a typical day when you are drinking?*

The international version of Question 3 of AUDIT-C and AUDIT and Question 1 of FAST reads:

*How often do you have 6 of more **standard drinks** on one occasion?*

The UK version reads:

*How often have you had **6 or more units if female**, **or 8 or more if male**, **on a single occasion in the last year?***

It is vital that practices are using the correct questions. DRINKS are clearly very different from UNITS. A "drink" might contain ten units!

As well as the shift in the UK version from measuring in "standard drinks" to **units**, the questions now make a **gender distinction** between the different definitions of a "binge" for men and women (i.e. 6 units in a day for women and 8 units in a day for men).

- **Three out of four practices included their own question about drinking on their registration form.**
  Questions like **"Do you drink alcohol?"** or **"How many alcoholic drinks do you drink in a week?"** were being asked of patients before they completed the screening questions. This meant that **many patients skipped the screening questions when they got to them**, **thinking they had already covered alcohol.** Questions like these are **not specific enough to constitute screening** and **should be taken off registration forms**.

- **None of the practices reviewed included a unit guide with these questions.**
  Patients **do not generally understand units** and **often seriously under-estimate the units they are consuming**. Where patients self-screen, it is therefore imperative that a **clear and complete unit guide** covering the major drinks consumed is included to help patients to complete unit questions using accurate estimates.

- **One practice reviewed was using the wrong scoring thresholds.**
  This practice thought that a score of 8+ on AUDIT-C triggered a full AUDIT not 5+. This meant that **over 100 individuals** scoring between 5 and 7 were thought to be Lower Risk when they needed to be screened using the remaining AUDIT questions and may, on full screening, have been identified as Increasing, Higher or High Risk/possibly dependent drinkers.

  This is of serious concern as this meant that a cohort of potential problem drinkers was missed. ***If this error is replicated across the country, this constitutes a serious public health concern.***

- **Re-registrations.**
  68% of patients recorded as **"not screened"** were **re-registrations.** At most of the practices reviewed, re-registering patients were not screened. Administratively, if patients move to a house outside the PCT area but within the catchment area of the practice, the patient re-registers as a patient of the new PCT.

  Re-registrations **impact on a practice's DES returns** most greatly where the practice is very close to the borough border. In one practice near the border, **80%** of those missed for screening were re-registrations.

  In other areas, the proportion of re-registrations is still high as a result of patients not responding to letters sent by the Health Authority to confirm their address.

Brief Advice

- **Only two (of four) practices were offering face-to-face Brief Advice.**

Of the four reviewed practices, three were offering some form of Brief Advice to Increasing and Higher Risk patients. Two practices were **offering face-to-face Brief Advice delivered by a Practice Nurse or HCA during the standard new patient health check**. **However, neither practice was using a standardised format or providing a Brief Advice leaflet for patients**.

- **Wrong intervention tools in use.**
  Another practice was sending paper-based "How Much Is Too Much?" Brief Advice tools **designed for practitioner use** to patients requiring Brief Advice or Extended Brief Interventions. These would not have been **easy for patients to understand** and would no doubt have had **little impact** on their drinking.

- **One practice was offering no intervention at all to those patients identified as Increasing or Higher Risk. This is of serious concern.**
  The alcohol DES is designed **to identify *and* intervene (i.e. offer appropriate support)** at an early stage in a person's drinking "career" and to therefore **prevent** alcohol-related harm to the individual and society. **It is essential that screening is not seen as the endpoint of the alcohol DES but as the first stage in a pathway for people with an alcohol misuse problem**.

Extended Brief Interventions

- **No practices reviewed were offering face-to-face Extended Brief Interventions (EBI) for Higher Risk drinkers (AUDIT score 16-19) in-house or via referral to alcohol specialists.**
  This finding was no surprise, since the lack of capacity to deliver Extended Brief Interventions within primary care (and other frontline services) is a **systemic issue**. Whilst the NHS and BMA contractual guidelines and other best practice guidance include EBI as a standard intervention offered to Higher Risk drinkers, there is **little capacity** within primary care for the provision of EBI (NHS & BMA 2011, 2010, 2009, & 2008; NICE 2010; Department of Health 2010).

  See **STEP 4 Extended Interventions** in our **Step-by-Step Guide in Section I** for some tips on how EBI could be provided within your local pathway.

Referral

- **There were very few referrals of patients identified as possibly dependent (AUDIT score 20+) into specialist alcohol treatment.**
  In fact, of the four surgeries reviewed, only one had referred patients to specialist alcohol treatment as a result of alcohol DES screening.

- **One review surgery identified six individuals as possibly dependent (AUDIT score 20+) but referred none of these patients for specialist support.**
  Of the six patients, **three later engaged with the local community alcohol service when their problem drinking became more chaotic** (i.e. alcohol-related hospital admissions or mental health problems were exacerbated). **It is disappointing that referral or, at least, some in-house support from a primary care practitioner was not offered to all patients identified as possibly dependent immediately post-screening.** The remaining **three patients had received no intervention** regarding their alcohol at the time of the review.

Unfortunately, this pattern was seems to be replicated across the borough.
In 2009-2010, **only 10 individuals** were referred to the local alcohol service as a result of new patient screening under the alcohol DES.

Coding

Scores of zero were not being coded in many cases.
Reception staff and some medical practitioners did not realise that scores of zero for AUDIT-C, FAST or AUDIT should still be coded and included in the return. **This resulted in the practice losing money for work they had done.**

Practices were also often using multiple or incorrect codes; many of which the annual search (usually conducted by the Practice Manager) failed to pick up. This is no doubt partly due to the different codes recommended for use since 2008 (i.e. five different codes for Brief Advice).

Three of the four practices reviewed did not have an agreed code for the delivery of Brief Advice or referral to specialist services (i.e. AUDIT score 20+).

	Practice 1	Practice 2	Practice 3	Practice 4
Number of newly registered patients screened with AUDIT-C or FAST	9k15	9k16	9K15	9k15 (38D3 in brackets to score)
Number positive & fully screened with AUDIT	38d4 (score in brackets)	9K17 EMISQUALI (score)	9K17	9k17 (38d4 in brackets to show score)
Number of Increasing Risk & Higher Risk drinkers	9k16	9K1A	9K1A	No code
Number of Increasing Risk & Higher Risk drinkers given brief intervention	38d3 (score in brackets)	9K1B	No code	No code
Number scoring >20 on audit referred for specialist advice	No code	9K14	Shown on the system as a referral	FUP referred 8HA5

TABLE 3. Codes used to record alcohol screening process by review practice

Manual searches
The review team found that Practice Managers who conducted **manual searches** collated **more accurate results** for the annual DES returns.

Alcohol codes on patient records: a concern
One surgery reported concerns on behalf patients about the implications of having particular alcohol-related codes on their patient records, such as those in use for Brief Advice and Extended Brief Intervention:

- **9k1A** Brief Intervention for excessive alcohol consumption completed
- **9k1B** Extended Brief Intervention for excessive alcohol consumption completed

The phrase "**excessive alcohol consumption**" worried practitioners at this surgery. They were concerned that practices would be obliged to include this information in letters for insurance companies. The review team reassured the surgery staff that drinking at Increasing or Higher Risk levels was not significant enough to include in any such correspondence. However, it is unfortunate that the code wording is not more closely in line with contemporary terminology and less provocatively phrased.

V. References

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VI. Glossary

AUDIT

The Alcohol Use Disorders Identification Test (AUDIT)—developed by the World Health Organisation and endorsed by the Department of Health—comprises ten questions covering consumption levels and alcohol-related problems. AUDIT scores indicate the level of risk associated with an individual's drinking.

AUDIT-C

AUDIT-Consumption refers to the first three questions of the full AUDIT that measure consumption levels and frequency. A score below 5 on AUDIT-C indicates that the individual is in the Lower Risk category and that no further intervention is required. Where score is 5 or above, the further seven AUDIT questions should be asked.

Binge

A binge is defined as drinking double the recommended limits or more: for men, drinking more than eight units of alcohol, and for women, drinking more than six units of alcohol, constitutes a binge.

Brief Advice

Brief Advice comprises short (five minutes), face-to-face, structured advice to encourage reduced consumption of alcohol to sensible or less risky levels. When delivering Brief Advice, a practitioner communicates tailored information on units, risks, the benefits of cutting down and tips for cutting down, and works with the patient to make a reduction plan. Brief Advice is modelled on key principles from Motivational Interviewing (MI): Feedback, Responsibility, Advice, Menu, Empathy, and Self-Efficacy (FRAMES).

Brief Intervention

See **Brief Advice.**

Extended Brief Interventions (EBI)

An EBI session is a 20-40 minute interaction between a practitioner and a patient based on the therapeutic principles of health behaviour counselling (e.g. Rollnick et al. 1999) or Motivational Interviewing (MI). EBI is offered after Brief Advice to patients who:

- have an AUDIT score 16-19
- and/or failed to benefit from Brief Advice (see page 19)
- and/or request further support with their drinking
- and/or in the practitioner's view, need further help to improve
- and/or are ambivalent about the need for changing their drinking
- and/or patient is highly motivated to change their drinking

Unlike Brief Advice, EBI usually requires follow-up appointments (up to four) to embed behaviour change. EBI aims to support an individual in achieving Lower Risk drinking or abstinence.

FAST

FAST is a four-item screening questionnaire developed for busy clinical settings from the Alcohol Use Disorder Identification Test (AUDIT). FAST is made up of four of the full AUDIT questions. FAST is a two-stage screening test that is quick to complete since more than 50% of patients will be identified by Question One. Where a patient is FAST positive, the remaining AUDIT questions should be asked and the scores from this and FAST totaled.

Identification

See **Screening**.

Increasing Risk

Indicated by an AUDIT score of 8-15. Also known as "Hazardous" drinking, Increasing Risk drinking is classified as:

- Men who regularly consume more than 3-4 units per day.
- Women who regularly consume more than 2-3 units per day.

Increasing Risk drinkers are at an increased risk of shorter- to longer-term alcohol-related problems. Brief Advice should be offered to all Increasing Risk drinkers.

High Risk/possible dependence

Indicated by an AUDIT score above 20. Patients drinking at High Risk levels will already have experienced harm as a result of their drinking and are likely to be alcohol dependent. Alcohol dependence is the result of high alcohol consumption that leads to dependence associated with a range of physical and psychological withdrawal symptoms when alcohol consumption is ceased or substantially reduced.

High Risk drinkers typically require specialist alcohol treatment, such as detoxification and/or psychosocial interventions, in order to reduce or cease their drinking.

Higher Risk

Indicated by an AUDIT score of 16-19. Also known as "Harmful" drinking, Higher Risk drinking is classified as:

- Men who regularly consume 8 units per day, which is over 50 units of alcohol per week
- Women who regularly consume 6 units per day, which is over 35 units of alcohol per week

Higher Risk drinkers are at a higher risk of shorter- to longer-term alcohol-related problems, including alcohol dependence. They are likely to already be experiencing significant harm as a result of their drinking. Brief Advice should be offered to all Higher Risk drinkers and, where this is not successful in reducing their drinking, Extended Brief Interventions.

Identification and Brief Advice (IBA)

Also known as **Screening and Brief Interventions (SBI).** IBA is an over-arching term encompassing opportunistic case finding (i.e. identification/screening)

followed by the delivery of simple alcohol advice (i.e. Brief Advice/Brief Interventions) to individuals who are not suitable, or not ready, for structured treatment.

Lower Risk

Indicated by an AUDIT score of below 7. Lower Risk drinking is classified as:

- Men drinking below 3-4 units a day.
- Women drinking below 2-3 units a day.

A Lower Risk individual drinks within the recommended drinking limits. No intervention is required except to reinforce the "sensible" drinking message.

Motivational Interviewing (MI)

Developed by Professors William R. Miller and Stephen Rollnick, Motivational Interviewing is a client-centred counselling style that focuses on exploring an individual's motivations for change, exploring and resolving ambivalence, and eliciting "change talk." The ultimate aim is to embed behaviour change. MI is the cornerstone of health behaviour change therapies in substance misuse, smoking cessation, and weight loss.

Screening and Brief Interventions (SBI).

See **Identification and Brief Advice.**

VII. Abbreviations

AUDIT	Alcohol Use Disorders Identification Test
AUDIT-C	Alcohol Use Disorders Identification Test – Consumption
BMA	British Medical Association
CMO	Chief Medical Officer
DAAT	Drug and Alcohol Action Team
DES	Direct Enhanced Service
EBI	Extended Brief Interventions
GP	General Practitioner
GPC	General Practitioner Committee
HCA	Healthcare Assistant
IBA	Identification and Brief Advice
LES	Local Enhanced Service
LMC	Local Medical Committee
MI	Motivational Interviewing
NICE	National Institute of Clinical Excellence
NHS	National Health Service
PCC	Primary Care Commissioning
PCT	Primary Care Trust
SIPS	Screening and Intervention Programme for Sensible Drinking

VIII. Appendices

Appendix A

ALCOHOL DES PRACTICE REVIEW SHEET

Download from www.haga.co.uk/Tools under "Alcohol DES Guidance Tools for Primary Care."

Information required by review team prior to visit:

- Previous two years of DES screening results (benchmarked against other practices)
- Previous year of Exeter new patient registration figures against DES reported figures

<table>
<tr><td>1.</td><td>Collating Information for the DES Return
TO BE COMPLETED WITH PRACTICE MANAGER
Purpose: To find out whether the process used to collect data for the return results in inaccurate data presented to commissioners.</td></tr>
<tr><td>1.1</td><td>Who collates the information for the DES return?</td></tr>
<tr><td>1.2</td><td>How does this person collate information to put in the return?</td></tr>
<tr><td>1.3</td><td>What codes are searched for each piece of information required for the DES return?
<table>
<tr><th></th><th>Code searched</th></tr>
<tr><td>• Number of newly registered patients screened with AUDIT-C</td><td></td></tr>
<tr><td>• Number screened with AUDIT</td><td></td></tr>
<tr><td>• Number of Increasing Risk (Hazardous) & Higher Risk (Harmful) drinkers</td><td></td></tr>
<tr><td>• Number of Increasing Risk (Hazardous) & Higher Risk (Harmful) drinkers given Brief Advice</td><td></td></tr>
<tr><td>• Number scoring >20 on AUDIT referred for specialist advice</td><td></td></tr>
</table></td></tr>
<tr><td>1.4</td><td>Where does the information about numbers of newly registered patients come from? [i.e. Is it the same as the number of patients screened? All newly registered patients? All patients aged over 16?]</td></tr>
</table>

2.	**Recording Screening information** **TO BE COMPLETED WITH PRACTICE MANAGER** **Purpose:** To find out whether screening results have been accurately coded.
2.1	A random search of 10 records of patients registered within the last year but not coded as screened (i.e. no AUDIT score). Record gender, ethnicity, age, disease registers, and postcode region to build up a profile of those patients missed.
	Record 1
	Record 2
	Record 3
	Record 4
	Record 5
	Record 6
	Record 7
	Record 8
	Record 9
	Record 10

3.	**Alcohol Screening, Intervention & Referral Process** **TO BE ANSWERED BY PRACTITIONER(S) RESPONSIBLE FOR BRIEF ADVICE** **Purpose:** To find out whether practices are screening accurately and support the DAAT to identify training gaps.	**Person interviewed**
3.1	Which alcohol screening tool is being used (i.e. AUDIT-C, FAST and/or AUDIT)? *[Find out whether practices are using their own alcohol screening question as a precursor to the standard alcohol screening tool i.e. "Do you drink? Yes/No]. Collect paper copy of registration form or see IT template as appropriate.]*	
3.2	At what point in the new patient check is alcohol screening introduced?	
3.3	Describe how you undertake the screening process. *For example:* *Engage – Ask opening question (" would you like to….") or registration form completed.* *Screen – Complete AUDIT-C. Where score 5+, complete AUDIT. (Add together AUDIT-C and AUDIT scores.)* *Feedback – Feedback score.* *No action – If AUDIT score is less than 7, no action required. Code on patient record.* *Brief Advice – If AUDIT score is 8-19, deliver five minutes of Brief Advice. Code on patient record.* *Extended Brief Interventions - If AUDIT score is 16-19, consider offering or referring for EBI.* *Refer – If AUDIT score is 20+, refer with patient consent to specialist alcohol treatment service. Code on record.*	
3.4	Who provides Brief Advice at the practice? Is it the same person who undertakes the screening? Do they use a Brief Advice tool? Is this given to the patient?	
3.5	Describe how you would provide Brief Advice. *[Keywords: cover score, risks, basic units, benefits of cutting down, strategy for reducing in an empathic, motivational style]*	
3.6	Do you have any provision for Extended Brief Interventions? i.e. are all Higher Risk drinkers given Brief Advice? Are staff trained in EBI in practice or do they refer Higher Risk drinkers to local alcohol service?	
3.7	Who coordinates referral into treatment?	
3.8	How are high scores (i.e. 16+) communicated to the GP?	
3.9	a. Who codes the screening, Brief Advice, or referral on your system? b. What codes are they using for each stage in the process? Compare these to those being searched in Section 1.3 above.	
3.10	What training have staff had in Identification and Brief Advice and/or Extended Brief Interventions? How often is this available?	

Appendix B Alcohol DES Screening Tool (AUDIT)

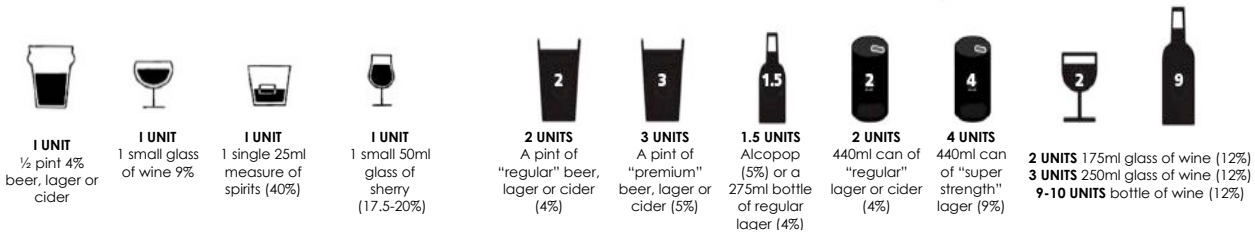
Download from www.haga.co.uk/Tools under "Alcohol DES Guidance Tools for Primary Care."

Alcohol Health Questionnaire – [INSERT PRACTICE NAME]

Instructions for Patients:

Please circle the correct answers and then hand into a member of the practice staff.

The unit guide below will help with calculating units.



1 UNIT ½ pint 4% beer, lager or cider

1 UNIT 1 small glass of wine 9%

1 UNIT 1 single 25ml measure of spirits (40%)

1 UNIT 1 small 50ml glass of sherry (17.5-20%)

2 UNITS A pint of "regular" beer, lager or cider (4%)

3 UNITS A pint of "premium" beer, lager or cider (5%)

1.5 UNITS Alcopop (5%) or a 275ml bottle of regular lager (4%)

2 UNITS 440ml can of "regular" lager or cider (4%)

4 UNITS 440ml can of "super strength" lager (9%)

2 UNITS 175ml glass of wine (12%)
3 UNITS 250ml glass of wine (12%)
9-10 UNITS bottle of wine (12%)

Questions	Scoring system					Your score
	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking? *(See unit guidance above.)*	1 -2	3-4	5-6	7-9	10+	
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	_____

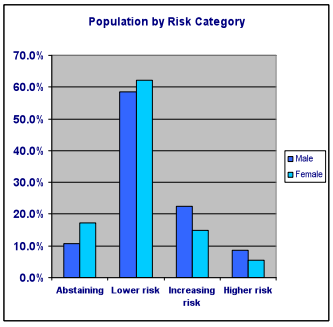
Appendix C

Alcohol DES Brief Advice Tool

Download from www.haga.co.uk/Tools under "Alcohol DES Guidance Tools for Primary Care."

What's everyone else like?

% of Adult Population



Tips for cutting down

- Have an alcohol free-day once or twice a week
- Plan activities and tasks at those times you would usually drink
- When bored or stressed have a workout instead of drinking
- Explore other interests such as cinema, exercise etc
- Avoid going to the pub after work
- Have you first drink after starting to eat
- Quench your thirst with non-alcohol drinks before and in-between alcoholic drinks
- Avoid drinking in rounds or large groups
- Switch to low alcohol beer / lager
- When you do drink, set yourself a limit and stick to it
- Avoid or limit the time spent with "heavy" drinking friends

Leaflet based on Drink Less materials originally developed at the University of Sydney as part of a W.H.O. collaborative study.

The benefits of cutting down

Psychological/Social/Financial
- Improved mood
- Improved relationships
- Reduced risks of drink driving
- Save money

Physical
- Sleep better
- More energy
- Lose weight
- No hangovers
- Reduced risk of injury
- Improved memory
- Better physical shape
- Reduced risk of high blood pressure
- Reduced risk of cancer
- Reduced risks of liver disease
- Reduced risks of brain damage

What targets should you aim for?

Men
Should not regularly drink more than 3–4 units of alcohol a day.
Women
Should not regularly drink more than 2–3 units a day

'Regularly' means drinking every day or most days of the week.
You should also take a break for 48 hours after a heavy session to let your body recover.

Making your plan

1. _____
2. _____
3. _____
4. _____

ALCOHOL BRIEF ADVICE TOOL

[Insert practice logo and contact details or other locally relevant image or text HERE]

Helping you to reduce your drinking

This is one unit...

For more detailed information on calculating units http://www.nhs.uk/Tools/Pages/Alcohol-unit-calculator.aspx


Half pint of regular beer, lager or cider (4%)


1 very small glass of wine (9%)


1 single 25ml measure of spirits (40%)


1 small 50ml glass of sherry (17.5-20%)


1 single 50ml measure of aperitifs (17.5-20%)

How many units did you drink today?

...and each of these is more than one unit

A pint of "regular" beer, lager or cider (4%)

A pint of "strong"/ "premium" beer, lager or cider (5%)

Alcopop (5%) or a 275ml bottle of regular lager (4%)

440ml can of "regular" lager or cider (4%)

440ml can of "super strength" lager (9%)

250ml glass of wine (12%)

Bottle of wine (12.5%)

There are times when you will be at risk even after one or two units. For example, with strenuous exercise, operating heavy machinery, driving or if you are on certain medication.

If you are pregnant or trying to conceive, it is recommended that you avoid drinking alcohol. But if you do drink, it should be no more than 1-2 units once or twice a week and avoid getting drunk.

Your screening score suggests you are drinking at a rate that increases your risk of harm and you might be at risk of problems in the future.

What do you think?

Risk	Men	Women	Common Effects
Lower Risk AUDIT Score 0-7	No more than 3-4 units per day on a regular basis	No more than 2-3 units per day on a regular basis	•Increased relaxation •Sociability •Reduced risk of heart disease (for men over 40 and post menopausal women)
Increasing Risk AUDIT Score 8 -15	More than 3-4 units per day on a regular basis	More than 2-3 units per day on a regular basis	*Progressively increasing risk of:* •Low energy •Memory loss •Relationship problems •Depression •Insomnia •Impotence •Injury •Alcohol dependence •High blood pressure •Liver disease •Cancer
Higher Risk AUDIT Score 16 -19	More than 8 units per day on a regular basis or more than 50 units per week	More than 6 units per day on a regular basis or more than 35 units per week	

AUDIT score 20+ High risk drinker and may be alcohol dependent. Specialist alcohol workers at **[INSERT CONTACT DETAILS HERE]** can help you tackle this problem. To self-refer, **[INSERT PHONE NO]** or your GP can help arrange a referral for you.

Want to drink less?

Information, advice and support is available from your GP and from specialist alcohol services.

In the *'Increasing Risk'* group? Your GP or Practice Nurse can offer 5 mins of **Brief Advice** that will help you reduce your drinking.

In the ***'Higher Risk'*** group? Your GP, Heathcare Assistant or Practice Nurse can offer you or refer you for an Extended Brief Intervention, lasting 20-40 mins, which will help you reduce or stop drinking.

[INSERT CONTACT PHONE NO] for further information on accessing this help.